MEDICAID/SLH/FAMIS APPEAL REQUEST FORM

First Name of Medicaid/SLH/FAMIS Applicant/Recipient:	Middle Name:	Last Name
Street or Post Office Box:		
City and State:	Zip Code – 9-Digit:	Contact Telephone #:
Medicaid/SLH/FAMIS Case #:	Social Security #:	Other Telephone #:

( ) I am appealing the action of (agency name) _____

( ) I am a community spouse appealing the income/resource maintenance standard.

The date on the letter or date I was told about the Medicaid/SLH/FAMIS decision is:_____

The person who spoke or wrote to me telling me about the action that I am appealing is:

Name: _____ Title: _____Telephone Number: _____

The agency (*check the appropriate space*):

( ) Placed/continued me in the Client Medical Management Program
( ) Denied me medical services or authorization for medical services
( ) Delayed my receipt of covered medical services. Name of service: _____
( ) Declared me not disabled by: (*please check one*) Medicaid Disability Unit ( ) Social Security ( )
( ) Changed, denied or proposed a change to my nursing home level of care
( ) Took other action which affected my receipt of Medicaid or medical services
( ) Failed to determine my eligibility within the time limit for: (*please check one*) ( ) Medicaid ( ) SLH ( ) FAMIS
( ) Declared me ineligible or canceled my eligibility for _____

***IMPORTANT* PLEASE SEND A COPY OF THE NOTICE OR LETTER ABOUT THE ACTION YOU ARE APPEALING.**

I have a representative: _____
(It is not necessary to have a representative) _____
_____
_____

(Name, Address, and Telephone # of Representative)

Signature of Appellant: _____ **Date:** _____

If this form is being signed by anyone other than the Medicaid/SLH/FAMIS applicant or recipient, please see back of form.

I am requesting a hearing because: _____
_____
_____
_____

See other side for instructions.

INSTRUCTIONS

1. **Complete this form as fully as possible or write a letter with the same information.**

2. **Include names, addresses and telephone numbers, please print.**

3. **The Medicaid/SLH/FAMIS applicant or recipient should sign the form. If the applicant or recipient cannot sign the form, explain why you are the appropriate representative. If you hold Power of Attorney (POA) include a copy of the POA agreement.** _____

4. **Mail this form or your letter to the address shown below.**
   - **The appeal form or letter must be *postmarked* within *thirty (30) days* of the agency's action.**
   - **The appeal form or letter must be *postmarked* within *thirty (30) days* of the date you were supposed to get a decision, but did not.**
   - **If neither of the above addresses your situation, mail in the appeal form or letter as soon as possible to protect your appeal rights.**

SEND COMPLETED FORM TO:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond Virginia 23219

IF YOU ARE NOT MAILING THE APPEAL FORM OR LETTER WITHIN *30 DAYS*
OF THE AGENCY'S ACTION, PLEASE ANSWER THE QUESTIONS BELOW.

1. **Did you get a denial or cancellation notice? _____What was the postmark date on the envelope? _____ When did you get the notice?_____**

2. **If you did not get a notice, how did you learn of the denial or cancellation?**
   _____

3. **Have you had any problems getting mail? _____ What kind of problems?_____**
   _____ Were problems reported to the post office?_____

4. **Has your address changed?_____ When?_____ Did you tell the agency?_____**
   When?_____

5. **Why didn't you file an appeal within 30 days of the agency action?** _____

   _____

   _____

   _____

   _____